10 Things Your Practice Should Know about PCMH

Considering becoming a Patient-Centered Medical Home? We’ve got answers to some of the most common questions about this recognition, what it means to your practice, and help for achieving it.

Answer:

PCMH is the Patient-Centered Medical Home, a model that is:

- Patient-centered
- Comprehensive
- Team-based
- Coordinated
- Accessible
- Focused on quality and safety
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The PCMH model has been around since 2007, but has become more important in recent years because:

- Your health plans may pay more - CMS, Wellpoint, Aetna and other health plans pay up to 10% more to PCMH practices
- Patients and health plans will view your practice as providing higher quality care
- Being recognized as a PCMH will make your practice more attractive to ACOs, resulting in increased revenue
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Answer:

14% of the Primary Care workforce, including 27,820 clinicians at 5,739 sites, has adopted the PCMH model. 37 states have public and private PCMH initiatives that use NCQA recognition.

How widespread is PCMH adoption?
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What are the 7 Joint Principles of PCMH?

Answer:

**Enhanced Access**
Improve access to healthcare by increasing same day/sick appointments and having 24/7 access to a physician either in the office or via phone after hours.

**Whole Person Orientation**
Serve as the patient’s main hub for all their care needs, mind, body, and spirit, referring to specialists as appropriate.

**Coordination of Care**
The physician has active relationships and contacts in the community for patient care (urgent care, ER, specialists) and has a process in place to receive follow up care regarding their patients.

**Personal Physician**
Emphasis on a strong patient-physician relationship.

**Quality & Safety**
Focus on evidence-based medical practice, improved chronic disease management, and better communication through technology applications.

**Physician-Directed Medical Practice**
Physician leads staff in creating more efficient office practices.

**Appropriate Payment Model**
 Appropriately recognizes the added value provided to patients who have a Patient-Centered Medical Home.
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Why does the PCMH model work?

Answer:

The PCMH model works because studies show:

• Patients seek the right care at the right place and time
• Patients are less likely to seek care from an ER or delay care
• Coordinated care means less duplicate or unnecessary tests
• Focus on wellness reduces chronic disease
• Better management of chronic disease improves population health
• Cost savings from healthier patients, appropriate use of medicine, less ER, less hospital and less readmits
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Answer:

The improvements seen with PCMH include:

- 60% decreased cost of care, lower number of emergency room visits
- 40% fewer hospital admissions
- 30% improved health indicators and preventative services
- 30% better access to primary care physician

What specific improvements have been seen with PCMH?
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Answer:

The American Academy of Family Practice (AAFP) has a handy checklist you can use to evaluate how many of the values your practice is utilizing at any point.

How do I evaluate my practice in terms of becoming a PCMH?
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Answer:

The average time required for a practice to convert to a Medical Home model is one year to 18 months. However, with appropriate software, your practice may be able to reduce the time required.

Time Required for Medical Home Conversion

- Less than a year: 12%
- One year to 18 months: 37%
- 18 months to two years: 23%
- More than two years: 12%
- Other: 16%
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**10 Things Your Practice Should Know about PCMH**

**Answer:**

Specialties that typically become medical homes include:

- Family practice
- General practice
- Internal medicine
- Pediatrics

The National Committee for Quality Assurance (NCQA) recently launched a Patient-Centered Specialty Practice (PCSP) Recognition program to recognize specialty practices that can demonstrate successful care coordination.
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Answer:

Transforming a practice into a medical home requires both workflow changes and software that will support the transformation and the reporting required.

1. Choose an EHR that is prevalidated by NCQA to support the PCMH transformation and provides autocredit.

2. Make the necessary changes to your practice workflow, as described by organizations including the AAFP.

3. Apply to receive recognition based on specific criteria. The NCQA Medical Home program is based on 3 achievement levels, with a points system determining which level of recognition your practice will receive. By using an EHR that is prevalidated for autocredit points, you can achieve Medical Home recognition more easily.
• MediTouch EHR is **PCMH Prevalidated by NCQA** to receive **23.5 points in Autocredit** toward NCQA's 2011 PCMH scoring. This helps reduce the amount of documentation your practice needs to gather and present to NCQA.

• **MediTouch received the highest amount of Auto-credit awarded to any ambulatory EHR system.**

• **MediTouch supports most all of the more than 40 reports required by NCQA** and there is never a need for a third party registry to manage your data and reporting.

• Streamline your process with **software designed to support the Medical Home: MediTouch.**

Find out how MediTouch will help streamline your transition to PCMH – schedule a demo today at (855) 342-4407 or HealthFusion.com